



*Office of the
Inspector General*

A PERFORMANCE AUDIT OF THE MEDICAID HOME HEALTH FEE-FOR-SERVICE PROGRAM

DO KHPA POLICIES AND PROCEDURES FOR THE HOME
HEALTH FEE-FOR-SERVICE PROGRAM PROMOTE GOOD
STEWARDSHIP OF GOVERNMENT FUNDS?

A Report to the Kansas Health Policy Authority Board, October, 2008

FY09-01



Office of the
Inspector General

October 30, 2008

To: The Members of the Kansas Health Policy Authority Board

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RE: A Performance Audit of the Medicaid Home Health Fee-for-Service Program

The Kansas Health Policy Authority (KHPA) Office of Inspector General (OIG) presents this audit report, which answers the question: **Do the Kansas Health Policy Authority (KHPA) policies and procedures for the Home Health Fee-for-Service program promote good stewardship of government funds?** This audit is issued pursuant to K.S.A. 75-7427(1), which states in pertinent part:

The scope, timing and completion of any audit or investigation conducted by the Inspector General shall be within the discretion of the Inspector General.

To accomplish the objectives of this audit, the Office of Inspector General made the following inquiries:

- a) What services are covered under the Home Health Fee-for-Service program?
- b) What controls are in place to ensure the appropriateness and accuracy of payments and to prevent fraud?
- c) What has KHPA done to promote cost savings in the Home Health Fee-for-Service program?
- d) Based on audit findings, what additional policy or program changes should KHPA consider implementing?

Audit results in brief are:

- KHPA has multiple strategies in place to reach the goals of appropriate and accurate payments, preventing fraud and achieving cost savings. These strategies appear to have had a positive effect. The OIG recommends KHPA continue to pursue these activities.
- The OIG also identified some weaknesses in high level strategies and internal controls, and made recommendations to address these specific areas, as further detailed in this report, and summarized below.
 - To help ensure that consumers receive appropriate services, the OIG recommends KHPA:
 - more closely manage its process that requires approval be obtained for certain services before those services are provided to consumers
 - ensure physicians, who determine whether home health services are medically necessary, adequately play the role of gatekeeper to the program
 - use each consumer's plan of care, a document that describes services that are medically necessary, to set limits on how many services will be paid for on behalf of the consumer
 - review documents related to consumers' health assessments to better understand the population and shape the program.
 - To help ensure that KHPA makes accurate home health payments, the OIG recommends that KHPA:
 - annually monitor the contract performance measures of its fiscal agent EDS
 - perform a program review of its payment system
 - expressly articulate the goal of accuracy in its strategic plan
 - collect data to identify the prescribing physicians and home health agency employees, which would allow for better oversight
 - collect the dates that services are provided to accurately verify compliance with KHPA policies
 - pay for partial units of service rather than full 15-minute units of service, which will better reflect the actual service provided
 - closely manage provider numbers by tracking multiple numbers and deactivating old numbers.
 - To help ensure that KHPA actively prevents fraud, the OIG recommends that KHPA:
 - identify health claims that allege services were provided to a consumer who has been admitted to a hospital or nursing home
 - increase communication with consumers regarding their services.
 - To help achieve cost savings, the OIG recommends that KHPA:
 - strive to project potential cost savings with any proposed policy changes and follow up to see if savings were realized
 - consider further limiting eligibility for consumers with certain diagnoses and implementing additional copayments
 - explore whether cost savings strategies used in other programs may be effective in the Kansas Medicaid Home Health FFS program.

This report is organized into five sections. First, there is an overview of the Home Health Fee-for-Service program. Then, the following four topics are addressed in turn: appropriateness of payments, accuracy of payments, prevention of fraud, and cost savings measures. This report will be available in full on the KHPA OIG's website at www.khpa.ks.gov/OIG.

If you have any questions about this report, please feel free to contact the OIG at (785) 296-1076 or OIG@khpa.ks.gov.

Sincerely,

Robin J. Kempf
Inspector General

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Audit Scope and Methodology

To achieve the objectives of this audit, the KHPA Office of Inspector General (OIG) analyzed Medicaid Management Information System (MMIS) data on home health claims paid during State fiscal years (FY) 2004 to 2007. To obtain assurance of the data's reliability, auditors reviewed external audits of MMIS. Auditors also reviewed KHPA's Medical Assistance Reports (MAR) for the same time period. *Note: The annual MAR data were gathered at earlier dates than the OIG-requested MMIS data. Any differences between the two datasets are likely due to claims adjustments made subsequent to the creation of the MAR.*

Auditors reviewed federal and several states' guidelines for Medicaid home health services and read literature relating to good practices and cost savings in home health and other billing programs. Also, auditors interviewed staff at KHPA, at KHPA's fiscal agent, EDS, and at the Attorney General's Office. Finally, auditors performed a file review of 10 home health case files related to KHPA's prior authorization process.

This audit was performed in accordance with generally accepted government auditing standards, with one exception. The standards require auditors to ensure any third parties participating in audit work comply with the professional standards and ethics applicable to auditors, but the OIG needed to rely on the Kansas Division of Information Systems and Communications (DISC) staff, who provide information technology support to KHPA, to decrypt confidential MMIS data. Neither the OIG nor KHPA currently have an agreement with DISC governing appropriate professional and ethical standards required of third parties; however, the OIG performed some tests of the data's integrity and concluded the evidence obtained provides a reasonable basis for OIG findings and conclusions based on the audit objectives.

All charts associated with the graphs in this audit report can be found in Appendix A.

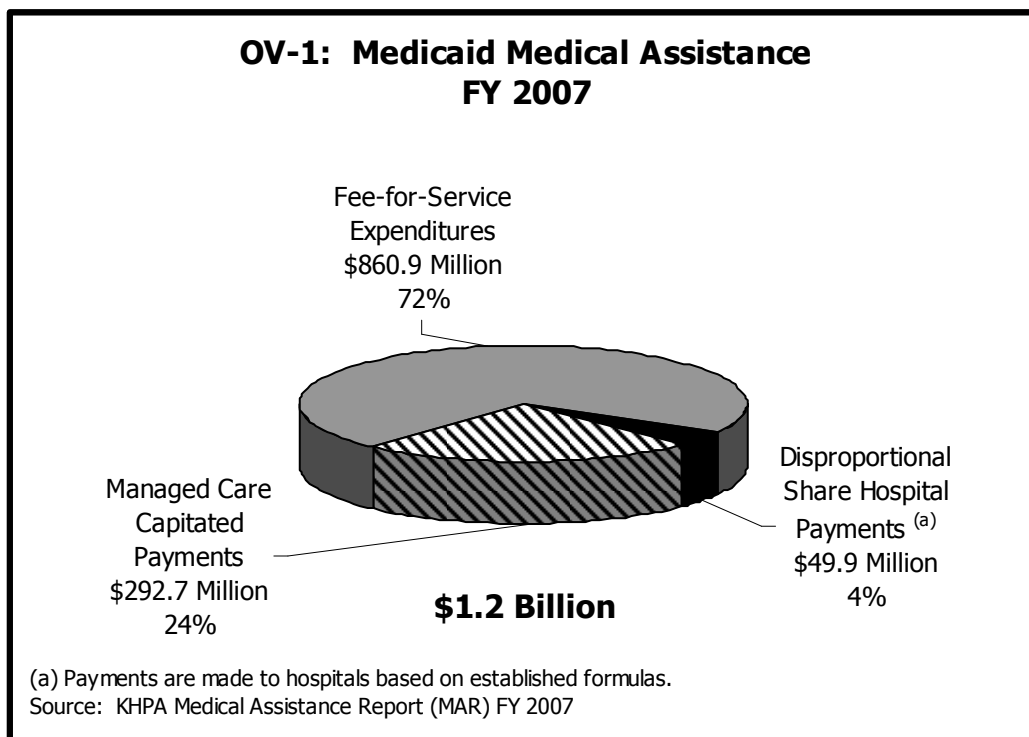
Glossary of Acronyms

ACIL	Attendant Care for Independent Living
BCBSKS	BlueCross BlueShield of Kansas
CMS	Centers for Medicare and Medicaid Services
DISC	Kansas Division of Information Systems and Communications
EDS	Electronic Data Systems
EOMB	Explanations of Medicaid Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FEIN	Federal Employer Identification Number
FFS	Fee-for-Service
FY	State Fiscal Year
GAO	United States Government Accountability Office
HCBS	Home and Community Based Service
HHS	U.S. Department of Health and Human Services
KHPA	Kansas Health Policy Authority
MAR	Medical Assistance Report
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
OASIS	Outcome and Assessment Information Set
OIG	KHPA Office of Inspector General
PPS	Prospective Payment System
SAS-70	Statement on Auditing Standards No. 70
SRS	Kansas Department of Social and Rehabilitation Services
SURS	Surveillance and Utilization Review Subsystem
TA	Technology Assisted

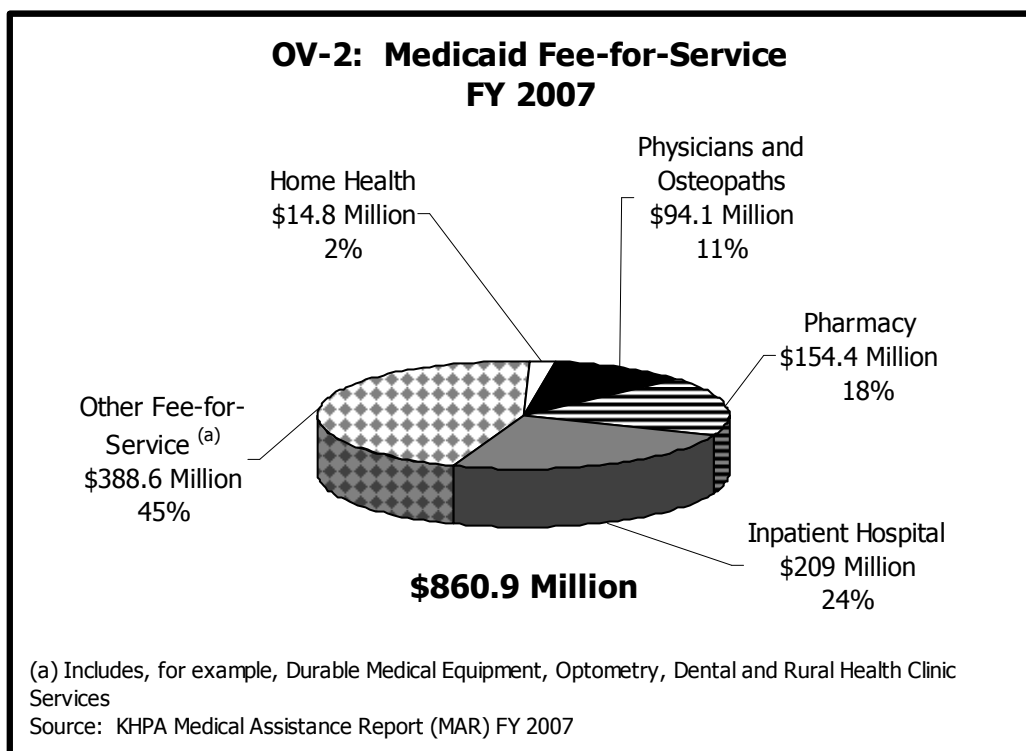
Overview of the Medicaid Home Health Fee-for-Service Program

What is the Medicaid Home Health Fee-for-Service (FFS) program? The Medicaid Home Health Fee-for-Service (FFS) program is a component of the Kansas Medicaid program, which provides medical services to low income Kansans. It is also a component of the Medicaid FFS program. In the FFS program, KHPA pays providers directly for the services they provide to eligible beneficiaries. Eligibility for FFS is largely limited to individuals who are aged or disabled. As shown in Chart OV-1, FFS accounted for 72% of Kansas Medicaid's medical assistance costs in fiscal year (FY) 2007.

Fee-for-Service may be contrasted with the other service delivery model used by KHPA to provide services in the Kansas Medicaid program: managed care. Managed care, which is not addressed in this audit, makes up approximately 25% of the medical costs of Medicaid. To provide managed care, KHPA pays managed care organizations (MCOs) a *per capita* fee, also known as a capitated payment, for each eligible beneficiary for which the MCO commits to provide services. Eligibility for managed care is largely limited to pregnant women, parents and children.



The FFS program is made up of subprograms based on the type of services provided to Medicaid beneficiaries. The Home Health FFS program, which is the subject of this audit, is only one of those subprograms. Other subprograms include physician services, inpatient hospital, pharmacy, durable medical equipment, and transportation, among others. As shown in Chart OV-2, expenditures for home health services amounted to nearly \$15 million or 2% of the total FFS costs for FY 2007.



Although the Home Health FFS program expenditures do not make up a large portion of FFS costs, the KHPA Office of Inspector General (OIG) recommended focusing on this program based on concerns expressed nationally and by KHPA staff about the general vulnerability of Medicaid home health programs to fraud.

What are home health services? In short, home health services are medically necessary services provided in the home. According to federal law, home health services, such as skilled nursing and home health aide services, are provided to a beneficiary at his or her place of residence on his or her physician's orders as part of a written plan of care.

Federal law mandates some specific home health services be provided by Medicaid but allows states to make other optional services available to eligible beneficiaries. According to the Kaiser Commission on Medicaid and the Uninsured, all states offer more than the minimum mandatory benefits in home health.

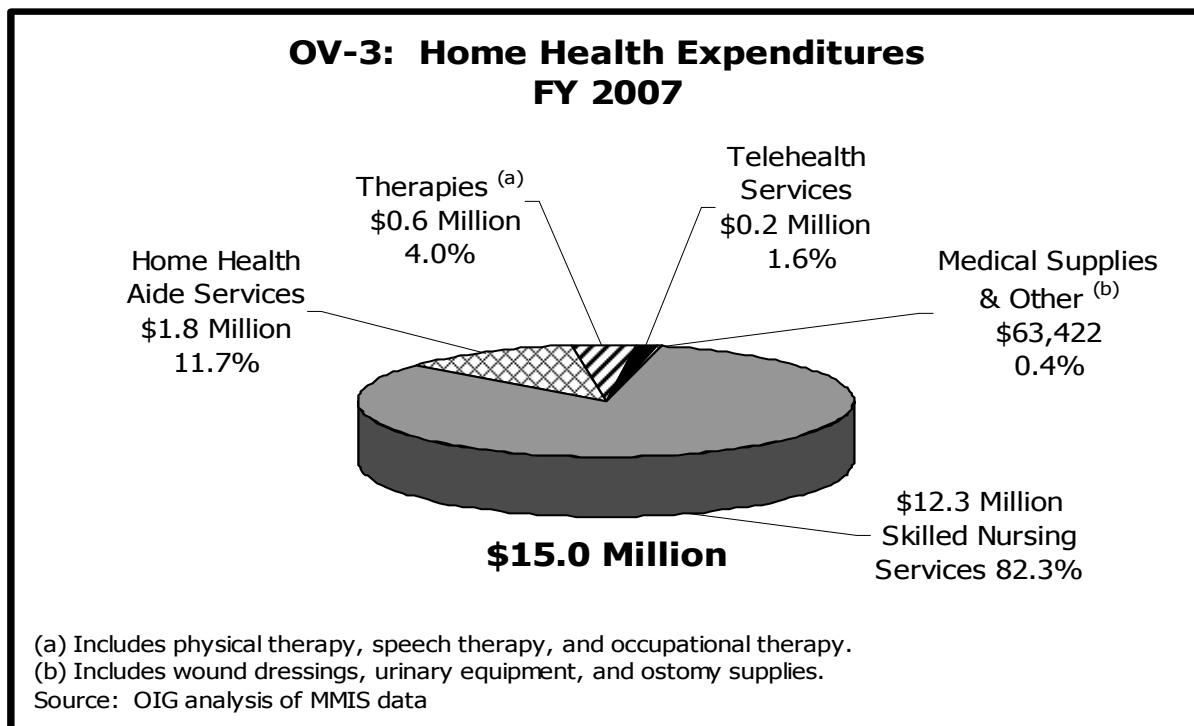
Auditors reviewed the benefits offered by KHPA's Home Health FFS and found:

- All home health benefits offered in Kansas are consistent with the federal Medicaid guidelines.
- Of the 14 types of home health services that KHPA offers, seven fall under federal mandatory guidelines while the remaining seven fall under federal optional guidelines.
 - Mandatory Benefits
 - Skilled Nursing Services

- Home Health Aide Services
- Medical Supplies
- Durable Medical Equipment
- Family Planning
- Immunization (as part of Early and Periodic Screening Diagnosis and Treatment (EPSDT))
- Kan Be Health Screening (also EPSDT)
- Optional Benefits
 - Occupational Therapy
 - Physical Therapy
 - Respiratory Therapy
 - Speech Therapy
 - Home Telehealth Services
 - Restorative Aide Services
 - Preventative Medicine

The most frequently used services in FY 2007 were skilled nursing and home health aide services, both of which are federally mandated services. Therapies (including speech, physical and occupational) and home telehealth services, which are optional services, were the next most frequently used. Chart OV-3 illustrates the breakdown of expenditures for various home health services.

Definition: For this report, “expenditures” are total dollars paid for Home Health FFS claims during a State fiscal year (FY).

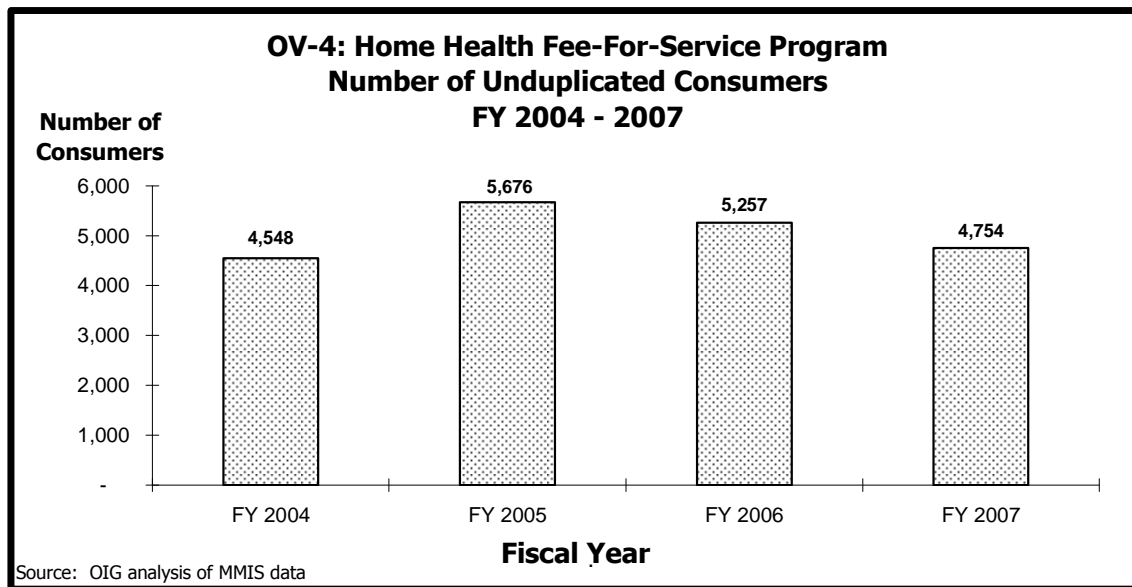


Who provides home health services to Medicaid FFS beneficiaries? In Kansas, only home health agencies certified by Medicare may enroll as providers in Medicaid; however, if there is a geographic location without a Medicare-certified home health agency, federal law allows a local health department to provide these services for Medicaid. KHPA verifies that home health agencies are certified by Medicare when the agencies enroll in the Medicaid Home Health FFS program. Currently, approximately 130 home health agencies in the state provide services for Medicaid FFS beneficiaries. These home health agencies are able to provide services throughout Kansas, except in one county. Logan County, in western Kansas, is served by the local health department.

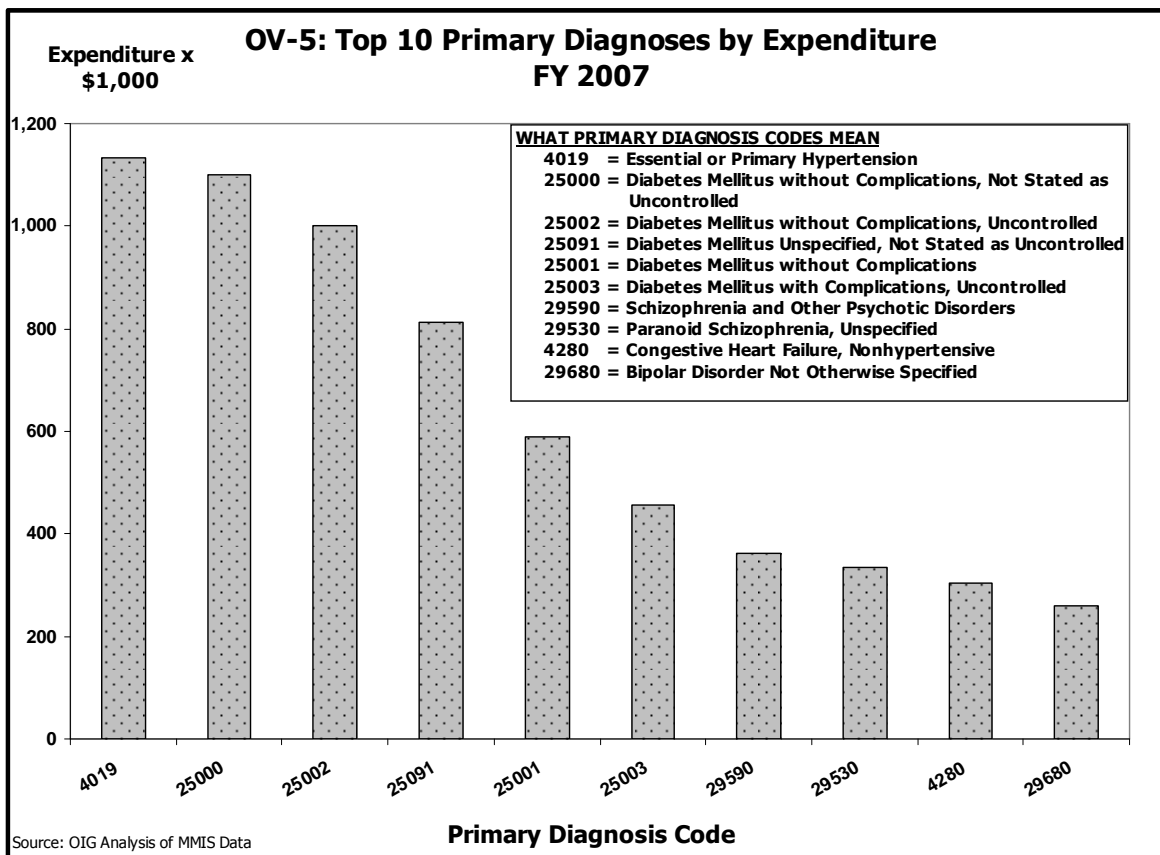
How many consumers receive home health services under Medicaid FFS? Auditors reviewed claims data for FY 2007 and determined there were about 4,750 unduplicated consumers of home health services that year.

Definitions: A “beneficiary” is any person eligible for Medicaid who may or may not have received services. A “consumer” is anyone for whom a claim was paid during the fiscal year.

As shown in Chart OV-4, after an initial rise in the total number of unduplicated consumers receiving services, numbers have dropped steadily over the last few fiscal years.



What type of Medicaid beneficiary receives home health services under Medicaid FFS? The most frequently reported primary diagnoses for home health consumers in FY 2007 were related to hypertension, diabetes and mental health. Chart OV-5 shows the expenditures made for the top 10 consumer diagnoses in FY 2007.



Auditors reviewed 10 cases of high need, home health consumers in FY 2007. Due to their medical conditions, these consumers were approved by KHPA to receive amounts of services that exceeded general policy limits. Some of these individuals are described below.

Case Studies: *Note: Since cases selected were from those having a high number of units of service billed, these consumers are likely to have more severe medical needs than the average home health consumer.*

A 46-year-old single consumer suffers from multiple sclerosis and has been wheelchair bound for 10 years. The consumer is unable to empty the bladder and cannot manage a catheter alone. Home health services ordered include a weekly injection, catheterization five times a day, medication monitoring and a catheter change once a week.

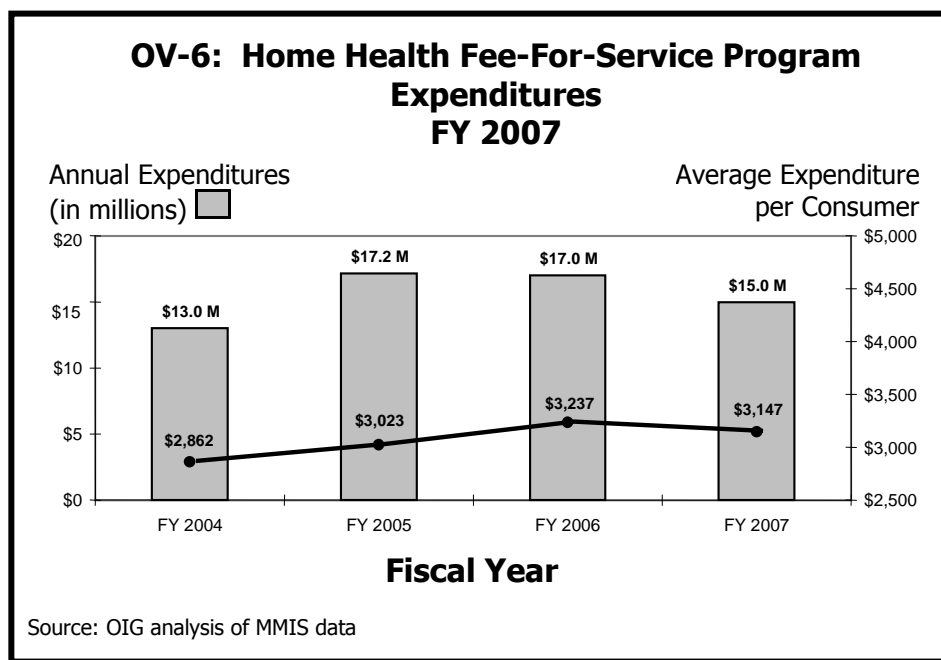
A 75-year-old consumer has been discharged from a hospital after experiencing an exacerbation of chronic obstructive pulmonary disease and congestive heart failure. The consumer also recently began dialysis. The consumer receives skilled nursing services to check compliance with the treatment regimen, set up medication, assess oxygen saturation, monitor vital signs, and assess the response to medication.

A 35-year-old consumer has schizophrenia and bipolar disorder, including hallucinations. The consumer has a history of drug abuse and is unable to self-administer medication properly. Skilled services received include medication administration, a review of vital signs, education on new medication and monitoring signs and symptoms of psychosis.

Source: Prior authorized files of FY 2007 Home Health FFS consumers

How is the Home Health FFS program funded? The Home Health FFS program is funded by both State and federal funds at a specific matching rate set by the federal government. This rate, which is recalculated annually is based on Kansas' *per capita* income, and is currently set at 39.92%-60.08%. In other words, the State funds about 40% of the cost of all FFS services, and federal funding is available for the remaining 60%. Additionally, Medicaid is the payer of last resort. If a beneficiary has insurance coverage of any kind, including Medicare, the other coverage must be applied first before reimbursement from Medicaid will occur.

What are the trends in Home Health FFS expenditures? Auditors' analysis of four years of claims data uncovered recent declines in home health spending, although the average cost per consumer appears to be increasing. These trends are illustrated in Table OV-6.



Part 1: An Evaluation of How KHPA Ensures Appropriate Payments

Summary: The KHPA Office of Inspector General (OIG) reviewed specific KHPA policies and procedures designed to ensure that payments are *appropriate* under Home Health FFS program guidelines. Auditors found that KHPA uses three primary strategies to ensure appropriate Medicaid payments:

- ❖ electronic edits and audits in the computerized claims processing system, known as the Medicaid Management Information System (MMIS);
- ❖ annual data analyses of programs, known as “program reviews,” completed by key management staff; and
- ❖ requiring approval be obtained for certain services before those services are provided to consumers, a process known as prior authorization.

The OIG recommends KHPA continue pursuing these efforts, which have shown some success. The OIG also recommends that KHPA strengthen the internal controls relating to its prior authorization process and extend its use of two tools at its disposal, which are underutilized: the consumer assessment form and the consumer plan of care.

KHPA has undertaken three initiatives in recent years to help ensure appropriate payments are made in the Home Health FFS program. Auditors found evidence that these initiatives may have had some success. Each approach is described in the bulleted paragraphs below.

Definition: For this audit, “appropriate payments” are those made for services that are medically necessary, as required by federal law, *and* that comply with the Home Health FFS policy manual.

- In recent years, KHPA’s program oversight appears to have significantly reduced the number of payments deemed inappropriate due to non-compliance with its policy manual. Auditors looked at home health claims paid during FY 2004-2007 and found that each year KHPA made some payments that did not comply with the Home Health FFS policy manual in effect at the time. In other words, auditors discovered KHPA paid for multiple home health procedure codes which were not included in the manual.

Nevertheless, auditors also found that the numbers of these non-compliant claims and the associated dollar amounts dropped significantly over this time period. As Table 1-1 shows, inappropriate payments have dropped from nearly \$1 million dollars in FY 2004 to about \$850 in FY 2007. The Home Health FFS Program Manager explained this was a result of updating the list of covered codes for the program.

**1-1: Total Costs Attributable to Inappropriate
Procedure Codes
FY 2004-2007**

Fiscal Year	Number of Inappropriate Procedure Codes Identified	Associated Expenditures
FY 2004	41	\$973,057
FY 2005	31	\$64,709
FY 2006	11	\$16,228
FY 2007	9	\$858

Source: OIG analysis of the Home Health FFS Provider Manuals and MMIS data

- The data driven annual program reviews launched in 2007 show great potential to assist KHPA in achieving the goal of appropriate payments. The creation of a data analysis team whose goals are to identify problems, propose solutions and regularly report on progress is a regulatory practice recommended by the federal government, and KHPA's annual program review process serves this important function.

Auditors concluded that the Home Health FFS program review was successful in addressing the issue of appropriate payments because it provided the program manager the opportunity to do two things: (1) suggest changes to the Home Health policy manual based on the data analysis of the program; and (2) identify areas where procedures could better ensure only medically necessary services are provided and reimbursed. The program review's resulting proposals for programmatic changes will be presented to the KHPA Board's Kansas Medicaid Transformation Committee. In addition, many of those proposals are referenced further in this report.

- KHPA has increased, and plans to further increase, its use of prior authorization, which may help achieve cost avoidance by reducing inappropriate payments in the Home Health FFS program. Prior authorization is a process by which KHPA requires its approval of certain services before those services are actually provided to a consumer. A home health agency submits the request for prior authorization on behalf of a consumer. This process helps to ensure only medically necessary services are provided to home health consumers, because only those consumers with appropriate medical documentation will be approved.

Since July 1, 2002, KHPA has increasingly imposed limits on the number of services, or "units", home health consumers may receive. These limits may only be overridden if a consumer qualifies through the prior authorization process. KHPA also requires prior authorization before home health services are provided to consumers receiving Medicaid through the Home and Community Based Services (HCBS) Medicaid waiver programs.

The figures in Table 1-2 show that over the last four calendar years, the number of prior authorization requests have dropped, which suggests unqualified consumers are not applying for prior authorization. Also, fewer units are being approved, which suggests cost avoidance is being achieved.

1-2: Home Health Prior Authorizations (PA) Approved Calendar Years 2004 – 2007						
Calendar Year	Number of PA Requests	Number of PA Approvals	% Approved	Units Requested	Units Approved	% Approved
2004	10,818	9,729	89.9%	557,648	467,351	83.8%
2005	10,254	9,862	96.2%	532,887	480,187	90.1%
2006	10,191	9,815	96.3%	495,013	431,201	87.1%
2007	10,024	9,527	95.0%	454,095	372,469	82.0%

Source: OIG analysis of EDS' Prior Authorization Unit data

Prior authorization may be achieving cost avoidance, but auditors identified several internal control weaknesses that may be reducing its effectiveness. The data in Table 1-2 shows that staff approved at least 90% of annual prior authorization requests from FY 2004-2007. This level of regular approval suggested to the auditors that approval was fairly easy to get.

In order to understand the prior authorization process better, auditors reviewed 10 cases of high need consumers who had received prior authorization for units of service that exceed policy limits. After that review and further discussion with KHPA staff, auditors concluded that the process has several internal control weaknesses, each of which relate to KHPA's allowing home health agencies opportunities to dictate which services they are paid for without KHPA's double checking that those services are appropriate. The issues are described in the bulleted paragraphs below.

- ❖ KHPA neither verifies whether a physician has reviewed and approved a plan of care prior to its granting prior authorization for a consumer, nor does it check whether home health agencies are maintaining physician-signed plans of care onsite.

Definition: A "plan of care", also called the HCFA-485, describes a consumer's medical condition, which home health services are necessary for him or her, and how often those services should be provided. In other words, the plan of care describes what services are *medically necessary* for the individual given his or her health status.

According to KHPA, the plan of care is completed by the home health agency, signed by a physician, and maintained at the home health agency. An unsigned version is submitted with the request for prior authorization.

As a regulatory tool, the requirement of a physician's signature helps ensure that a home health agency is not over-prescribing services and then billing Medicaid. In other words, the physician serves as a gatekeeper for those requesting prior authorization by confirming medical necessity. Yet KHPA does not have a method to determine whether

that gatekeeper is playing its proper role, and as a result, KHPA will authorize services based solely on a home health agency's assessment.

- ❖ KHPA allows the prior authorization of six months of services, although the supporting plan of care expires after 60 days. After authorizing six months of services, KHPA does not check to see whether any additional supporting documentation was completed during that time period. Further, KHPA directs home health agencies to submit a new plan of care during the six months only if the consumer's condition has changed, but does not check whether home health agencies comply with this requirement. This lax regulatory oversight allows the opportunity for inappropriate payments to be made.
- ❖ The KHPA OIG reviewed 10 prior authorization cases, and in all cases, payments appeared to exceed the frequency or duration of services prescribed in the consumers' most recent plans of care. For example, one consumer was billed for 61 units (more than 15 hours), of skilled nursing services in one day, but that consumer's plan of care only prescribed insulin injections twice a day and oral medication administration once a day, combined with health assessment and monitoring. Because the case files indicated that Medicaid might be paying for services that appear to be inappropriate due to the lack of medical necessity, the OIG referred all 10 cases to the Home Health FFS program manager for further review.
- ❖ KHPA does not require home health agencies and physicians to specifically prescribe the number and duration of services that are medically necessary for consumers. Auditors observed that it is particularly difficult to quantify the extent to which paid claims exceed amounts approved in the plan of care because currently, plans of care do not specify the duration of units of service deemed necessary for each consumer. The lack of specificity makes regulatory oversight more difficult.

Recommendation: KHPA should re-examine its process for prior authorization to determine whether it is achieving the dual goals of ensuring consumers receive appropriate services and keeping unnecessary costs down. In particular, the OIG recommends KHPA address the internal control weaknesses described above. KHPA should only pay for claims which are confirmed to be medically necessary for consumers. KHPA's weaknesses in addressing medical necessity could lead to criticism from the U.S. Department of Health and Human Services (HHS) Office of Inspector General, as has occurred in other states.

The OIG additionally recommends KHPA further address appropriateness of payments through the use of two tools already at its disposal. These findings and recommendations are described below.

KHPA does not review consumers' written plans of care, except in cases requiring prior authorization or if the home health agency is subject to an audit by KHPA. Otherwise, KHPA staff told auditors they assume these plans of care are properly signed by a physician and properly maintained. This assumption is based on the fact that all home health agencies participating in Kansas Medicaid must be certified to participate in Medicare and the certification requires that a plan of care be completed and maintained for every consumer.

Just as the failure to review signed plans of care in the prior authorization process is a weakness in trying to ensure Medicaid only pays for medically necessary services, it is also problematic regarding the population of consumers who receive home health services under the limits set by KHPA. Without looking at these documents, KHPA cannot know whether the services paid for are medically necessary. As stated above, in its review of Medicaid home health programs in other states, the HHS Office of Inspector General found that several states were unable to consistently demonstrate their payments for home health services were medically necessary. By failing to review plans of care, KHPA places itself in the same position.

As a result of its home health program review, KHPA has proposed to carefully examine the needs of the population who are receiving services under policy limits. This plan would likely require a review of consumers' plans of care. While auditors do not disagree with that approach, the auditors recommend KHPA use the plan of care in a more direct manner as described in the following recommendation.

Recommendation: The OIG recommends the services described in a consumer's signed plan of care be entered into the Medicaid Management Information System (MMIS) and used to set limits on the number of services that can be billed by a home health agency for that particular consumer. Auditors have learned that the Home and Community Based Service (HCBS) Medicaid waiver programs similarly enter electronic plans of care into MMIS. By using the plan of care in this way, the Home Health FFS program would be assured that KHPA would pay for only those services deemed medically necessary by a physician.

- KHPA does not review consumers' Outcome and Assessment Information Set (OASIS) forms, except in cases requiring prior authorization. The OASIS form provides a written assessment of an individual to determine his or her physical and mental capabilities. It is used by a home health agency to draft an appropriate plan of care. Home health agencies are required to complete the OASIS for each consumer. In Medicare, OASIS data is submitted electronically to CMS and continually monitored to assess the quality of care consumers receive, but in Medicaid, the OASIS is not regularly reviewed.

Recommendation: Auditors recommend the acquisition and evaluation of OASIS data for all Medicaid Home Health consumers, not just those for whom prior authorization is requested. This information would help KHPA understand the population of consumers receiving these services, assess their needs, and better shape program benefits to best meet those needs.

Part 2: An Evaluation of How KHPA Ensures Accurate Payments

Summary: The KHPA Office of Inspector General (OIG) reviewed specific KHPA policies and procedures designed to provide *accuracy* in payments for home health services. Auditors found that KHPA uses two primary strategies to ensure Medicaid payments are accurate:

- ❖ electronic edits and audits in the computerized claims processing system, MMIS; and
- ❖ post-payment audits of providers.

Auditors observed these strategies appear adequate; however, KHPA could implement several high level and internal control strategies to further promote accuracy of payments.

KHPA uses two primary approaches to help ensure accurate Medicaid payments. The first approach occurs prior to making a payment. KHPA directs its fiscal agent, Electronic Data Systems (EDS), to employ multiple electronic edits and audits in the computerized claims processing system, MMIS, which ensure only accurate data is entered in to and processed by the system. The second approach occurs after payment has been made. KHPA directs EDS staff to perform audits of paid claims to identify and correct inaccuracies that may have occurred. This post payment review process is called the Surveillance and Utilization Review Subsystem (SURS) and requires the physical review of consumers' medical files by medically trained staff.

Auditors did not conduct an in-depth evaluation of the appropriateness or effectiveness of MMIS edits and audits. Instead auditors relied on Ernst & Young's March 2007 SAS-70 audit report on MMIS controls, which found that the computer controls tested were operating with sufficient effectiveness to provide reasonable assurance that objectives such as payment accuracy were being achieved. Furthermore, auditors reviewed the SURS practice manual and interviewed EDS staff to understand the process but did not evaluate the effectiveness of that approach due to time limitations. Nevertheless, through observation, the auditors concluded KHPA's strategies related to electronic edits and post payment reviews are sound in concept.

While the systems KHPA has in place appear adequate, the OIG found places where KHPA's high level strategies to promote good stewardship regarding accuracy could be improved. The OIG recommends the following three approaches, which are based on auditors review of good practices.

Recommendation: KHPA should monitor EDS' progress on its performance measures, as is described in their contract. During the course of this audit, the OIG learned that KHPA staff had not recently checked whether EDS was meeting contractual performance measures. According to the contract with EDS, this process should occur annually. Auditors found that KHPA last completed this review in 2006 and communicated recommendations to EDS in February 2007. Good practices for contract monitoring dictate that when an agency like KHPA depends on an outside contractor to perform important functions, a strong contractual relationship and continuous monitoring of the contractor's performance becomes vital to achieving agency goals.

Recommendation: KHPA should complete a data-driven program review, such as has been done for the Home Health FFS program, on the accuracy of the payment system, including an evaluation of the effectiveness of MMIS' edits and audits. Auditors observed that KHPA and

EDS staff tend to use a reactive approach to correcting problems related to accuracy as opposed to a strategic evaluation of the entire system. For example, when auditors asked for a high level description of how staff addresses accuracy, auditors were referred to EDS's Project Workbook website for a detailed list of the edits and audits put into place in recent years. Furthermore, while EDS staff could provide auditors with data on overpayments found through the SURS post payment reviews, they could not provide comprehensive information on the success of MMIS' edits and audits.

Clearly, KHPA and EDS continually work to improve MMIS; however, the concern is that the staff's focus on details results in their inability to see the big picture. In other words, the processes in place tend to address individual edits and audits rather than assessing the system as a whole. A high level program review would provide management with information that would help them assess how well strategies are working and whether improvements are needed.

Recommendation: To support its goal to be a good steward of government funds, KHPA leadership should expressly articulate the importance of accuracy as a primary goal of MMIS. The auditors' review of good practices regarding accuracy of payments indicated that upper management should articulate that accurate billing is a priority and be willing to support staff in the pursuit of that goal. The concept of accurate billing is clearly encompassed by the KHPA vision principle of stewardship, which states: "The Kansas Health Policy Authority will administer the resources entrusted to us by the citizens and the State of Kansas with the highest level of integrity, responsibility and transparency." Yet, the OIG encourages *express* articulation of accuracy as a goal, and to do so, suggests setting accuracy in payments as one of the objectives in its strategic plan.

The OIG also identified weaknesses in some internal controls specifically related to the Home Health FFS program that should be addressed. The first recommendation is described below, and the remaining recommendations are found in Table 2-1.

Recommendation: KHPA should collect identifying data about the physicians who order home health services for consumers and the home health agency employees that actually provide the services. Currently, KHPA does not collect electronic information on either of these groups even though both play an important role in consumers' healthcare, and without basic information about these individuals, KHPA's ability to monitor home health is limited.

The following case study illustrates that if KHPA collected and analyzed a prescribing physician's identification, KHPA could prevent payments based on illegitimate physicians' plans of care. In addition, analyses about physicians' practice patterns with regard to home health could be pursued.

Case study: The U.S. Senate Committee on Homeland Security and Governmental Affairs' Permanent Subcommittee on Investigations held a hearing in July 2008 about Medicare payments for durable medical equipment (DME) claims. A review of the identities of the doctors who had allegedly prescribed the DME found that many of those doctors had died at least one year before the dates of service on the claims. In other words, DME providers were requesting reimbursement from Medicare using the identification numbers of deceased doctors as support. The Subcommittee's press release stated that "[t]he Subcommittee's analysis of Medicare claims data revealed that, from 2000 through 2007, Medicare payments for DME claims containing the [identification numbers] of deceased physicians ranged from an estimated \$60.3 million to \$92.8 million."

Auditors attempted to investigate whether this problem might be occurring in Kansas but were unable to draw any conclusions because, unlike in Medicare, the prescribing physician's identification is not collected in MMIS.

The following case study illustrates that if KHPA collected information about the identification of a home health agency's employees, KHPA could electronically determine whether that individual's billed hours are appropriate according to industry standards of employees' hours worked.

Case study: The Attorney General's Medicaid Fraud and Abuse Division is investigating a case of alleged fraud in which a home health agency billed for services supposedly provided by a single nurse to multiple consumers that sometimes exceeded 18 hours a day. According to the Division, this pattern of billing continued for four to five years. The abuse was only identifiable through a review of medical records because no electronic information is available about the individual home health employees.

KHPA staff noted that although physicians have identification numbers, home health agency employees do not have such a number. Implementation of this recommendation may require a home health agency to create and assign a unique number to each employee providing service to Medicaid clients.

Additional recommendations about internal controls relating to accuracy are summarized in Table 2-1 on the following page.

2-1: Additional OIG Recommendations for Several KHPA Internal Controls		
KHPA's Current Practice	OIG Comment	OIG Recommendation
<u>Date Range Billing:</u> KHPA allows home health agencies to bill for a lump sum of services provided during a period of days. The period could include as many as 15 days. Home health agencies are not required to specify the date on which any particular service was provided.	The lack of specification makes it impossible to accurately verify through the MMIS electronic edit and audit process whether services billed meet per-day policy requirements. The only method to verify compliance is to compute an average. Thus, a time-consuming physical review of medical records is required to determine whether billings were compliant with home health policies.	KHPA should require home health agencies to specify the date services were provided within the date range. KHPA should also create the necessary edits in MMIS to verify compliance with KHPA policy.
<u>Full Unit Billing:</u> KHPA directs providers to bill only full units of service. One unit of service is 15 minutes. If 16 minutes of service is provided, a home health agency bills for two full units.	This imprecise method of billing provides a means by which a home health agency could easily increase its reimbursement by spending one more minute with a consumer than is necessary. The only way to identify this type of abuse is to perform a thorough post payment review of medical records.	KHPA should direct home health agencies to bill for partial units based on the actual amount of time service is provided. MMIS is currently capable of converting fractions of units to a percentage of a unit payment.
<u>Multiple provider numbers may be used:</u> KHPA told auditors that all providers have a unique provider number; however, in the review of home health claims from FY 2004-2007, auditors identified seven home health agencies that billed for services during that time using more than one provider number. Auditors subsequently learned that a home health agency might have more than one number based on their specialties.	KHPA does not have an easy way to track all the numbers associated with one provider. This issue was identified by the Centers for Medicare and Medicaid Services (CMS) when it reviewed and certified the current MMIS. To address the issue, CMS suggested EDS create a cross reference table to track all numbers associated with a provider.	KHPA and EDS should create a table in MMIS that cross references provider identification numbers.
<u>Old provider numbers are not immediately deactivated:</u> If a provider changes its federal employer identification number (FEIN), due to change in ownership or structure, KHPA issues a new provider number but relies on the provider to request that the old number be deactivated. If no request is received, the provider number is turned off after 18 months of inactivity.	Waiting a full 18 months to deactivate old numbers creates an opportunity for providers to submit duplicate claims without being discovered by MMIS.	KHPA should turn off old provider numbers promptly. If needed, KHPA should create a method to allow for the payment of claims billed under the old provider number. In addition, KHPA should review for duplicate claims in the case that a provider has more than one active number.
Source: OIG analysis of MMIS data, interviews with KHPA and EDS staff.		

Part 3: An Evaluation of How KHPA Prevents Fraud

Summary: The KHPA Office of Inspector General (OIG) reviewed KHPA's policies and procedures intended to *prevent fraud* in the Home Health FFS program. Auditors found KHPA uses two primary strategies to prevent fraud:

- ❖ electronic edits and audits in the computerized claims processing system, MMIS; and
- ❖ post payment audits of providers.

To further address fraud, the OIG recommends KHPA implement two additional strategies:

- ❖ identifying when a home health agency bills for services allegedly provided during a time when the consumer is not living in his or her home; and
- ❖ increasing direct communication with consumers.

Although it is difficult to quantify the amount of fraud in any health benefits system, the OIG found the number of investigations of fraud in the Home Health FFS program is not proportional to its percentage of expenditures. Six of the 73 cases, or 8%, being investigated by the Attorney General's Medicaid Fraud and Abuse Division at the beginning of July 2008 were related to the Home Health FFS program. Yet, the Home Health FFS program made up only 2% of the total FY 2007 FFS expenditures and 1.5% of the total FY 2008 FFS expenditures.

Case Study: The following are incidents the Medicaid Fraud and Abuse Division is currently investigating. According to the Division, these are a small subset of allegations against a single home health agency:

- ❖ Falsified visits to insulin dependent patients: The home health agency billed Medicaid for the maximum number of minutes per day that may be billed without prior authorization; yet several consumers reported that nurses visited only once a week to set up the injections needed for that time period. Consumers also reported one visit per week was sufficient and they had no knowledge the agency was billing for an hour a day.
- ❖ Providing services that were not medically necessary: The home health agency billed Medicaid to provide an over-the-counter allergy medication to a healthy school age child with a broken arm. It also billed for skilled nurses to provide pills to consumers with hypertension who the agency described as "forgetful."
- ❖ Falsification of documents: The home health agency's employees were instructed to complete paperwork to support services that were never provided. The Division identified one nurse who provided only 25% of the services that she claimed and for which her employer billed.
- ❖ Inflated salaries to employees, suggesting collusion: The home health agency paid its staff at levels much higher than the average regional salaries. In one case, a nurse earned as much as 50% higher than local rates.
- ❖ Threatening beneficiaries: The home health agency targeted beneficiaries with low education, high poverty, and mental or cognition problems. Agency staff told beneficiaries if they reported the agency to KHPA or the Medicaid Fraud and Abuse Division, they would lose their benefits.

Strategies KHPA currently uses to prevent fraud are the electronic edits and audits in the computerized claims processing system, MMIS, and post payment audits of providers. Both strategies are essential for addressing fraud. Computerized edits and audits prevent obviously fraudulent payments from being paid in the first place, and audits of providers identify irregular or fraudulent payments that might have already occurred and initiate recoupment of those dollars.

While the systems KHPA has in place are important, the OIG recommends KHPA take two additional steps to further prevent fraud. The OIG recommends the following approaches, one of which relates specifically to the Home Health FFS program, and the other which is derived from the auditors' review of good practices.

Recommendation: KHPA should take steps to identify when a home health agency bills for services allegedly provided during a time when the consumer is not living in his or her home. For example, KHPA could create an alert in MMIS to identify when the data shows there is a conflict between a consumer's dates of hospitalization or nursing home placement and billed home health services. Currently KHPA does not have a method to do so.

Under federal law, consumers who are admitted to a hospital or a nursing home are ineligible for services provided in the home. Yet, other states have identified cases where home health agencies billed Medicaid in such situations. To identify whether this type of fraud was occurring in Kansas, auditors analyzed claims data for FY 2007 to determine how that data related to other data identifying a consumer's location. Auditors made two findings.

First, auditors found they could not accurately assess whether billings were submitted while a consumer was in a hospital or nursing home because, as discussed earlier, KHPA allows home health agencies to bill for a lump sum of services provided within a date range without specifying the exact date the services were provided. Second, auditors were able to identify multiple incidents in which the date range of the home health billing overlapped with the times MMIS identified these individuals were in a living situation incompatible with home health. These incidents involved 38 consumers, 25 home health agencies and 89 claims billed, which amounted to approximately \$8,000. Although the dollar amount is not very high, this weakness in the system could easily be exploited to allow for fraudulent billing.

The overlapping dates were reported to KHPA staff, and staff told auditors these overlaps may be the result of a time lag in updating data in MMIS after a consumer's change of location. Staff also told auditors that some of these changes are completed by staff at the Kansas Department of Social and Rehabilitation Services (SRS). The OIG referred these cases to KHPA staff for further review and will follow-up to ensure cases appearing to be fraudulent are promptly referred to the Medicaid Fraud and Abuse Division or to SRS, as is appropriate.

Recommendation: KHPA should explore increasing communication with beneficiaries as a means to prevent fraud. Auditors observed that KHPA communicates relatively infrequently with consumers in the Home Health FFS program. Generally, that communication only happens if a consumer has been selected as one of 400 Medicaid FFS beneficiaries to receive an Explanations of Medicaid Benefits (EOMB) letter, which is a description of the services billed to

Medicaid on a consumer's behalf. In addition, a consumer might be contacted if the home health agency providing services becomes subject to a post-payment audit or a fraud investigation. This level of contact is insufficient as the consumer is a natural check on the actions of the provider. As such, the OIG recommends that KHPA examine how it could communicate more frequently with consumers in a cost effective manner. Perhaps, KHPA could consider sending an increased number of EOMBs or use a satisfaction survey to solicit consumers' input about the services they are receiving.

Part 4: An Evaluation of KHPA's Efforts to Achieve Cost Savings

Summary: The KHPA Office of Inspector General (OIG) reviewed KHPA's past efforts and proposals for the future relating to cost savings in the Home Health FFS program and found that KHPA has used multiple strategies to achieve cost savings. However, auditors found that KHPA generally makes policy changes that have the primary intent of improving service delivery, or achieving effectiveness and efficiency rather than reducing costs in the program. The OIG recommends that KHPA consider cost savings every time policy changes are proposed, and, after implementation, verify whether cost savings were realized. In addition, the OIG describes three large programmatic changes discussed on the federal level that KHPA should consider.

KHPA has implemented 17 policy changes in the Home Health FFS program from FY 2002 through FY 2007, and KHPA staff report these changes have resulted in cost savings. A review of these policy changes, as well as the proposed changes identified in the Home Health program review, indicates that KHPA has employed or plans to employ all four of the typical methods used by states to reduce costs in Medicaid programs. Those strategies include:

- Tightening or limiting eligibility for particular services or Medicaid as a whole
- Requiring consumers to pay a small dollar amount, or co-payment, for the services they receive
- Reducing or freezing provider reimbursement rates
- Reducing the number of benefits covered by Medicaid

KHPA's efforts in each of these areas are described in Table 4-1 on the next page. In certain cases, the OIG makes recommendations for further such efforts. Additionally, based on its review of policies, the OIG makes the following recommendation.

Recommendation: When pursuing policy changes in the Home Health FFS program, KHPA should ensure potential cost savings are considered for every proposal, and, after implementation, verify whether cost savings were realized. A review of the documentation relating to these policy changes showed staff generally focused on improving service delivery, effectiveness, and efficiency rather than cost savings. Auditors found only one of the 17 policies projected potential cost savings. The remaining policies stated cost savings were either "none," "unknown," or "not applicable."

Further, even though KHPA staff attributed decreasing expenditures in the Home Health FFS program to the broad policy changes, they generally could not quantify what cost savings were attributable to which policy or to what extent a policy was actually effective in achieving cost savings. Other than a reported study on the impact of a policy change regarding telehealth, staff has not regularly reviewed the post-implementation cost impact of the policies in a detailed way. If KHPA were to project potential cost savings and review whether those savings were achieved, that information would help determine if further policy changes are merited.

4-1: OIG Review of KHPA Cost Saving Strategies		
Strategy	KHPA Actions	OIG Recommendation
Tightening or limiting eligibility	<ul style="list-style-type: none"> Since 2003, all consumers receiving Medicaid through the Home and Community Based Services (HCBS) waiver programs must demonstrate medical necessity through the prior authorization process before being allowed to receive home health services. KHPA proposes to determine whether those consumers with acute care needs should have different access to services than those with long term chronic needs. 	<ul style="list-style-type: none"> KHPA should consider placing limits on eligibility for the Home Health FFS program similar to those used by Medicare, the Missouri Medicaid Program and BlueCross BlueShield of Kansas (BCBSKS). These entities limit eligibility to beneficiaries that show some level of being homebound. KHPA should also consider denying eligibility for certain categories of chronic diagnoses, like Medicare, Missouri, and BCBSKS do. For example, these entities disqualify individuals with the primary diagnosis of hypertension unless the individual has a unique medical need for skilled care in the home.
Requiring a co-payment	<ul style="list-style-type: none"> KHPA requires consumers to pay \$3 for each skilled nursing visit. 	<ul style="list-style-type: none"> KHPA should examine whether a co-payment should be required for home health aide visits, therapies or telehealth. These are the most utilized home health services outside of skilled nursing.
Reducing or freezing reimbursement rates	<ul style="list-style-type: none"> In 2007, KHPA reduced reimbursement rates by switching from a per-visit payment to a per 15-minute unit payment. In 2007, KHPA reduced the reimbursement for home telehealth services from \$45.67 to \$30.00. 	<ul style="list-style-type: none"> The OIG has no recommendation at this time. Auditors compared Kansas Medicaid's reimbursement rates with Missouri Medicaid's and found that Kansas nearly always reimburses at a lower rate for skilled nursing and home health aide services. This finding suggests KHPA's rates are already low.
Reducing the number of benefits	<ul style="list-style-type: none"> KHPA limits the number of services a consumer may receive without proving, through the prior authorization process, that he or she has a medical necessity for the services. KHPA has set some limits for services, such as occupational and speech therapies, which may not be overridden with prior authorization. 	<ul style="list-style-type: none"> The OIG has no recommendation at this time. Auditors compared the benefits offered by Kansas Medicaid to those offered by Missouri and Iowa's Medicaid programs and found that KHPA generally offers more services than the other programs. Nevertheless, the services deemed optional under federal law only made up 5.6% of KHPA's program expenditures in FY 2007. Even if these services were reduced, cost savings would be minimal, and a reduction might have the unintended consequence of increasing long term costs.
Source: OIG interviews with KHPA staff and research on other state and private industry practices.		

The OIG identified other cost saving strategies being explored on the federal level that should be examined for feasibility in Kansas. Three approaches in particular are worth exploration by KHPA: a payment system based on providing incentives to providers to keep costs low, a vigorous analysis of home health agency practice patterns to identify inefficient providers, and providing incentives to physicians who closely coordinate home health consumers' care. These three concepts and the accompanying OIG recommendations are found in the bulleted paragraphs that follow.

- Medicare employs a payment system that attempts to reduce the incentive for home health agencies to bill for as many visits as possible. Prior to adopting the current Prospective Payment System (PPS), Medicare, like Kansas Medicaid, paid home health agencies for each visit to a consumer. Under that payment plan, home health agencies had a financial incentive to visit consumers as often as possible, whether or not visits were needed.

Now, Medicare employs its PPS, which pays home health agencies for services to a consumer based on that consumer's diagnosis and condition. PPS pays a home health agency a flat fee for a 60-day period of care. Medicare will pay for visits after 60 days only when medically necessary. The PPS creates new incentive for home health agencies, which is to maximize their profit by either providing the least amount of services during the 60-day time period or reducing their cost per visit. It should be noted that an important consequence of adopting PPS is regulators must now review the quality of care a consumer receives to ensure his or her health is not worsening due to inadequate or too infrequent care. KHPA staff identified the complexity of such a system as a significant barrier to implementation, and the OIG agrees.

Recommendation: The OIG agrees that PPS is quite complex, yet the OIG recommends, as KHPA considers further cost savings plans in the Home Health FFS program, it pay attention to the incentives provided to home health agencies and try to encourage the provision of appropriate and quality care.

- The United States Government Accountability Office (GAO) has developed a methodology to study physicians' practice patterns with regard to Medicare consumers in order to identify inefficient providers. The GAO was able to identify outliers who were less efficient than their peers and suggested CMS explore a range of incentives to help encourage efficiency.

Definition: For this purpose, "efficiency" is defined as providing a sufficient level of service to meet a patient's health care needs, but not an excessive level of service, given the consumer's health status.

Recommendation: KHPA staff should perform a similar efficiency study of the home health industry to identify which providers might need education on how to efficiently provide care. The data could also identify programmatic changes necessary to encourage the efficient provision of services, including the creation of monetary or non-monetary incentives to encourage providers to be efficient and reduce program costs.

- CMS is conducting a demonstration project examining the effect of paying physicians for coordinating care in Medicare. This project is similar in concept to the medical home model that KHPA promoted as a key point of health reform in the 2008 legislative session. Under CMS' demonstration project, incentive payments (in addition to FFS payments) were provided to physician groups meeting performance measures relating to improved health outcomes. The first performance year of the demonstration project was recently reviewed by the GAO. They found that care coordination programs showed promise, but based on the structure of the project, wider use of the incentive payments might be limited.

KHPA staff proposes similar strategies to those embodied in CMS' demonstration project. First, staff proposes the creation of a diabetic management program for those individuals with diabetes receiving home health services. Second, staff proposes coordination with SRS and Kansas' community mental health centers to improve services to consumers with mental illnesses.

Recommendation: The OIG recommends KHPA consider paying physicians a fee to actively coordinate the care of consumers receiving home health services, particularly those with chronic illnesses. Alternatively, KHPA could employ the concept of the medical home in the Medicaid Home Health FFS program.

Conclusion and Recommendations

Overall, the KHPA Office of Inspector General (OIG) found evidence that KHPA is actively managing its Home Health Fee-for-Service (FFS) program. Continued close scrutiny and data analysis should propel KHPA forward toward improvements in appropriate and accurate payments, fraud prevention and cost savings. The OIG encourages KHPA to carry on in the direction it has begun.

The OIG also recommends KHPA address several areas of the Home Health Fee-for-Service program that should be strengthened to reach the goal of good stewardship. The OIG recommends the following regarding appropriateness of payments:

1. KHPA should re-examine its prior authorization process to determine whether it is achieving the dual goals of ensuring consumers receive appropriate services and keeping unnecessary costs down. In particular, KHPA should address internal control weaknesses identified by this audit and only pay claims that are confirmed as medically necessary by physicians.
2. In order to ensure KHPA only pays for services that are medically necessary for a consumer according to a physician-signed plan of care, KHPA should use those plans of care to set the number of services a home health agency may bill for that consumer.
3. KHPA should acquire and evaluate health assessment information found in the mandatory OASIS form for all Medicaid Home Health consumers, not just those requesting prior authorization in order to understand the population of consumers receiving these services, assess their needs, and shape program benefits to best meet those needs.

The OIG recommends the following regarding accurate payments:

4. KHPA should annually monitor the progress EDS, the Medicaid fiscal agent, makes on its performance measures, as is required in the contract between KHPA and EDS.
5. KHPA should complete a data-driven program review, such as has been done for the Home Health FFS program, on the accuracy of the payment system, including an evaluation of the effectiveness of MMIS' edits and audits.
6. To support its goal to be a good steward of government funds, KHPA leadership should expressly articulate the importance of payment accuracy by setting that goal as one of the objectives in KHPA's strategic plan and communicating that priority to staff.
7. To increase its capabilities to monitor the Home Health FFS program, KHPA should collect identifying data about physicians ordering home health services and the home health agency employees actually providing the services.
8. KHPA should require home health agencies to specify the actual dates services are provided to consumers, as opposed to simply identifying a date

range within which services are provided, and then create the necessary edits in MMIS to verify compliance with KHPA policy.

9. KHPA should direct home health agencies to bill for partial units of service based on actual minutes of service provided, instead of allowing providers to bill for 15-minute units regardless if one minute or 15 minutes of service are actually provided to a consumer.
10. KHPA should carefully manage its active provider identification numbers by: (1) implementing a table that identifies and cross references all provider identification numbers associated with a provider, and (2) by deactivating old provider numbers promptly.

The OIG recommends the following regarding fraud prevention:

11. KHPA should take steps to identify when a home health agency bills for services allegedly provided during a time when the consumer is not living in his or her home and therefore is ineligible for home health services.
12. To help identify fraud, KHPA should pursue increased communication with beneficiaries who serve as a natural check on the actions of providers. Methods to do so could include an increased number of mailings to consumers describing the services billed on their behalf or by using consumer satisfaction surveys.

The OIG recommends the following regarding cost savings:

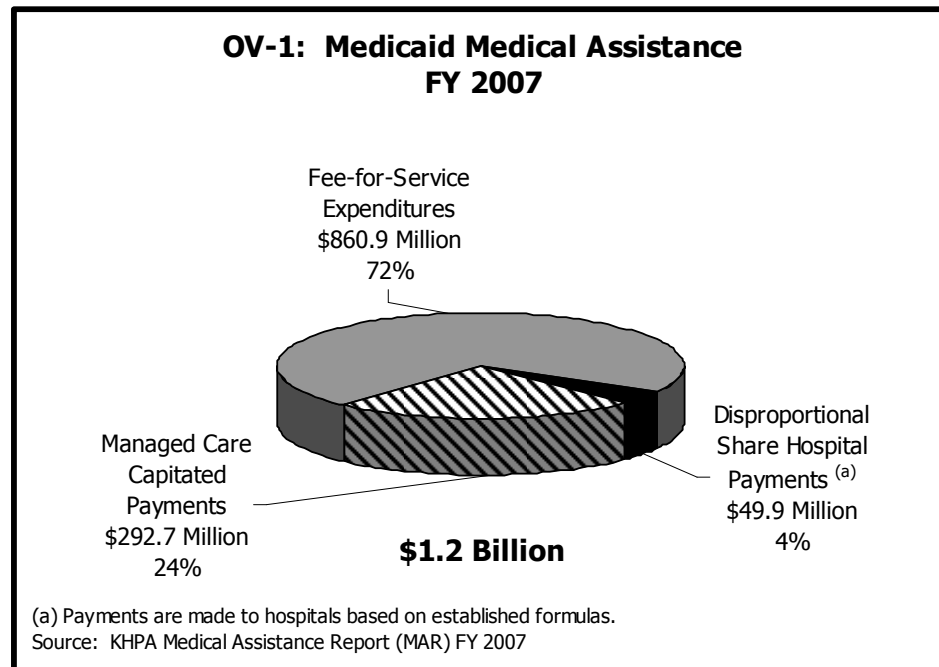
13. When pursuing policy changes, KHPA should ensure that potential cost savings are considered for each proposal, and after implementation, verify whether cost savings were realized.
14. KHPA should consider placing limits on eligibility for home health services that are similar to limits used by Medicare, Missouri Medicaid and BlueCross BlueShield of Kansas, which require home health consumers to show some level of being homebound or meet specific diagnoses criteria.
15. KHPA should examine whether a co-payment should be required for other home health services besides skilled nursing.
16. KHPA should consider cost savings strategies, such as:
 - a. modifying the payment system to provide incentives to providers to encourage the provision of appropriate and quality care;
 - b. performing a vigorous analysis of home health agency practice patterns to identify inefficient providers and identify programmatic changes to encourage the efficient provision of services; or
 - c. paying physicians a fee to actively coordinate the care of consumers receiving home health services, consistent with the concept of a medical home.

Appendix A

Charts and Tables for Audit 09-01

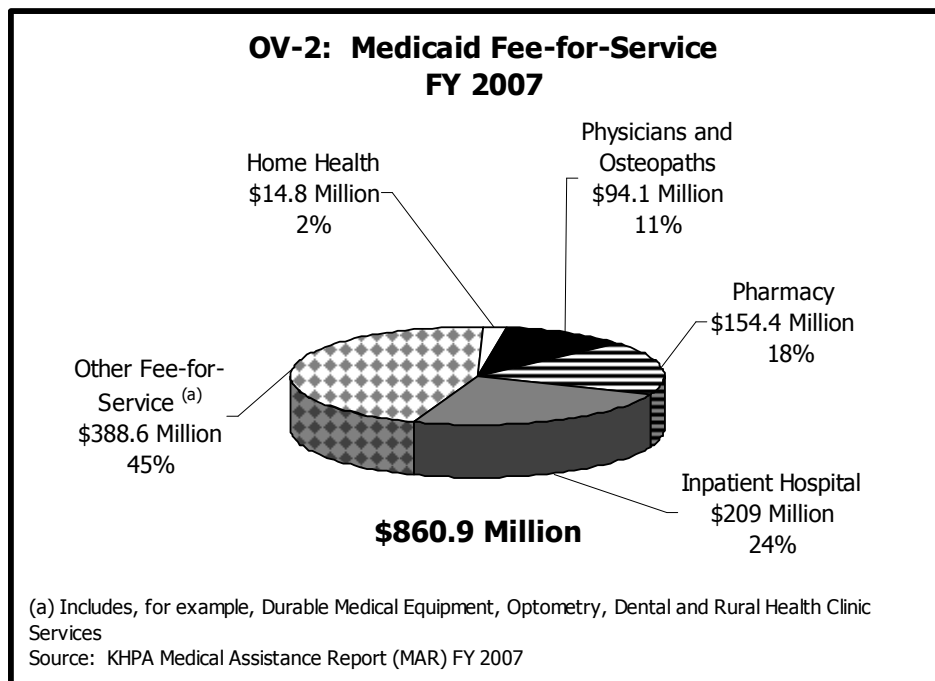
The following pages contain the charts included in this audit report and their corresponding tables.

Chart and Table for OV-1: Medicaid Medical Assistance FY 2007, found on page 4.



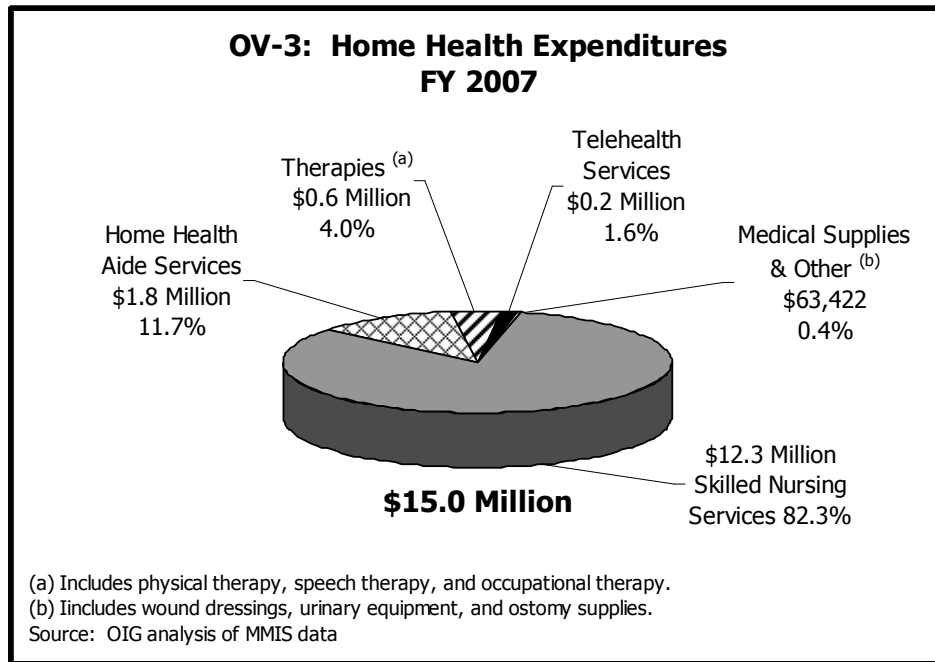
FY 2007 MEDICAL EXPENDITURES		
CATEGORY OF EXPENDITURE	\$ AMOUNT	% OF TOTAL
Total Fee-for-Service Expenditures	\$860,898,671	72.0%
Total Managed Care	\$292,685,870	24.0%
Total Disproportional Hospital Payments	\$49,924,871	4.0%
TOTALS	\$1,203,509,412	100%

Chart and Table for OV-2: Medicaid Fee-for-Service FY 2007, found on page 5.



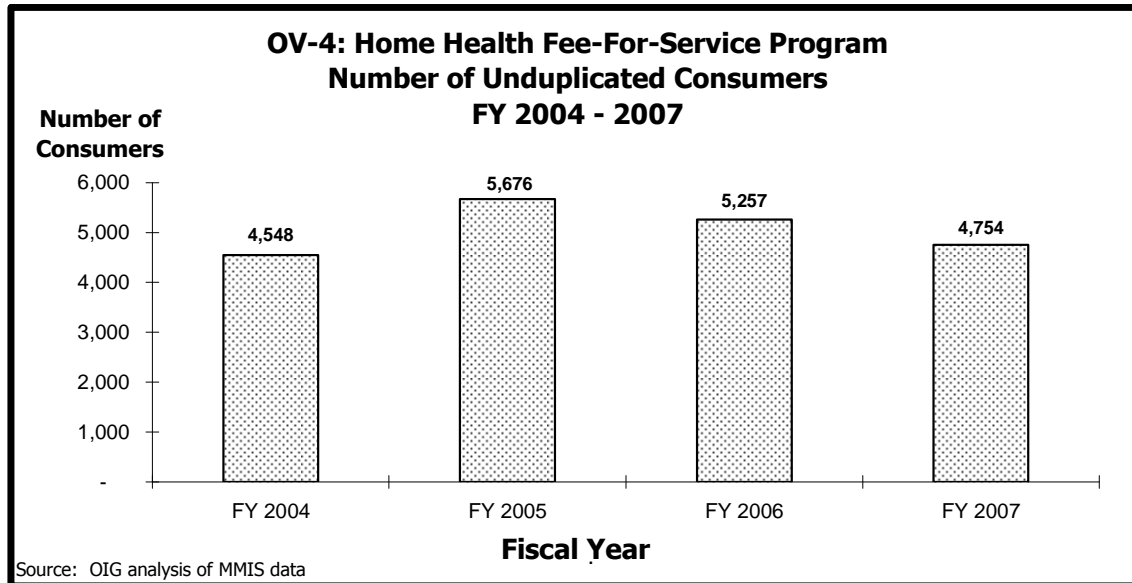
MEDICAID FEE FOR SERVICE EXPENDITURES IN FY 2007		
CATEGORY	FY 2007 EXPENDITURES	% of TOTAL
Other Fee-for-Service ^(a)	\$388,590,327	45.1%
Inpatient Hospital	\$209,045,901	24.3%
Pharmacy	\$154,414,936	18.0%
Physicians and Osteopaths	94,057,267	10.9%
Home Health	\$14,790,240	1.7%
TOTALS	\$860,898,671	100.0%
^(a) Includes, for example, Durable Medical Equipment, Optometry, Dental and Rural Health Clinic Services		

Chart and Table for OV-3: Home Health Expenditures FY 2007, found on page 6.



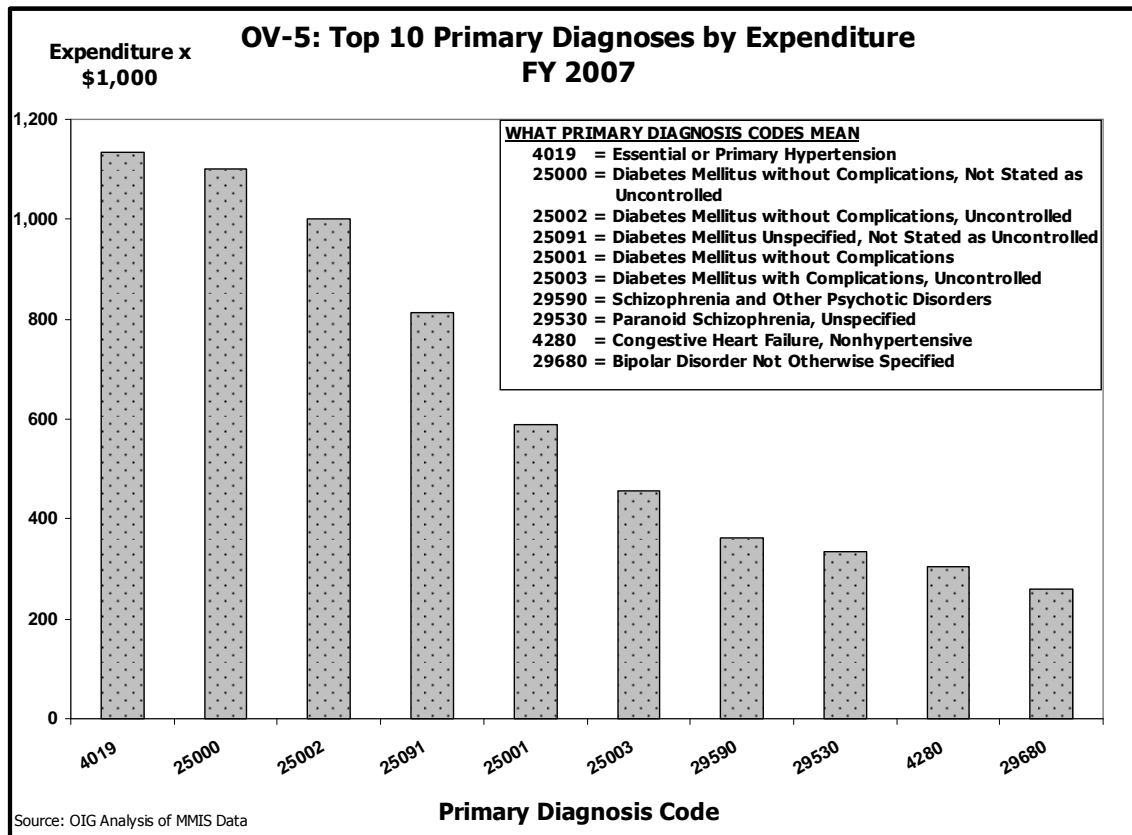
HOME HEALTH EXPENDITURES BY SERVICE CATEGORY FY 2007		
CATEGORY	FY 2007 EXPENDITURES	% of TOTAL
Skilled Nursing Services	\$12,309,729	82.3%
Home Health Aide Services	\$1,751,577	11.7%
Therapies ^(a)	\$591,786	4.0%
Home Telehealth Service	\$243,924	1.6%
Medical Supplies & Other ^(b)	\$63,422	0.4%
TOTALS	\$14,960,438	100.0%
^(a) This includes physical therapy, speech therapy, and occupational therapy.		
^(b) This includes things such as wound dressings, urinary equipment, and ostomy supplies.		

Chart and Table for OV-4: Home Health Fee-for-Service Program Number of Unduplicated Consumers FY 2004-2007, found on page 7.



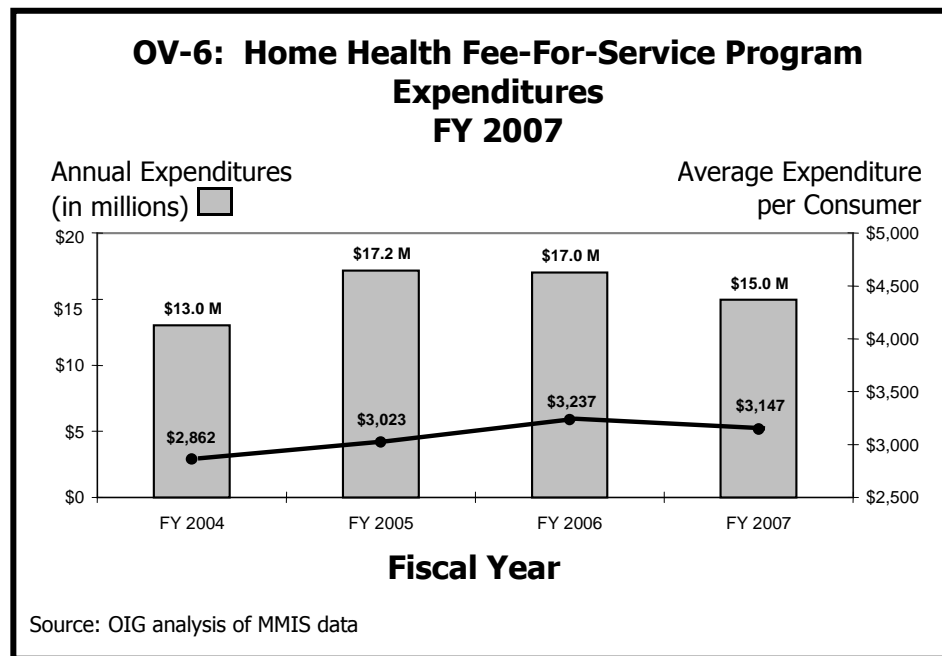
HOME HEALTH PROGRAM FEE-FOR-SERVICE NUMBER OF UNDUPLICATED CUSTOMERS FY 2004 - FY 2007		
FISCAL YEAR	NUMBER OF CONSUMERS	% CHANGE
FY 2004	4,548	
FY 2005	5,676	24.8%
FY 2006	5,257	-7.4%
FY 2007	4,754	-9.6%
TOTAL CHANGE OVER 4 YEARS:		7.8%

Chart and table for OV-5: Top 10 Primary Diagnoses by Expenditure FY 2007, found on page 8.



TOP 10 PRIMARY DIAGNOSES BY EXPENDITURE IN FY 2007			
PRIMARY DIAGNOSIS CODE	PRIMARY DIAGNOSIS CODE DESCRIPTION	TOTAL EXPENDITURE	% OF TOTAL HH EXPENDITURE
4019	Essential or Primary Hypertension	\$1,134,067	7.58%
25000	Diabetes Mellitus without Complications, Not Stated as Uncontrolled	\$1,100,414	7.36%
25002	Diabetes Mellitus without Complications, Uncontrolled	\$999,750	6.68%
25091	Diabetes Mellitus Unspecified, Not Stated as Uncontrolled	\$814,015	5.44%
25001	Diabetes Mellitus without Complications	\$588,342	3.93%
25003	Diabetes Mellitus with Complications, Uncontrolled	\$457,074	3.06%
29590	Schizophrenia and Other Psychotic Disorders	\$361,580	2.42%
29530	Paranoid Schizophrenia, Unspecified	\$335,883	2.25%
4280	Congestive Heart Failure, Non-hypertensive	\$303,125	2.03%
29680	Bipolar Disorder Not Otherwise Specified	\$260,979	1.74%
EXPENDITURES FOR TOP TEN DIAGNOSES		\$6,355,229	42.49%

Chart and Table for OV-6: Fee-for-Service Home Health Program Expenditures FY 2007, found on page 9.



HOME HEALTH FFS PROGRAM EXPENDITURES FY 2004 - FY 2007						
FISCAL YEAR	ANNUAL EXPENDITURES	% OF CHANGE	NUMBER OF CONSUMERS	% OF CHANGE	AVERAGE COST PER CONSUMER	% OF CHANGE
FY 2004	\$13,017,482		4,548		\$2,862	
FY 2005	\$17,161,251	31.83%	5,676	24.80%	\$3,023	5.63%
FY 2006	\$17,014,368	-0.86%	5,257	-7.38%	\$3,237	7.08%
FY 2007	\$14,960,438	-12.07%	4,754	-9.57%	\$3,147	-2.78%

APPENDIX B

Agency Response

On August 5, 2008, the KHPA Office of Inspector General (OIG) provided a copy of the audit report to the KHPA Executive Director and her executive team. A written response to the report was received but was subsequently withdrawn based on comments from the KHPA Finance and Audit Committee, a committee of the KHPA Board, on September 8, 2008.

Also, in response to comments from the KHPA Finance and Audit Committee, the OIG completed an amended audit report. Changes to the report were limited to:

1. a reduction of jargon in preference for plain English;
2. the inclusion of tables to accompany the report's graphics, which can be found in Appendix A; and
3. the change of the term "best practices" to "good practices."

On October 20, 2008 an amended audit report was resubmitted to the KHPA Executive Director and her executive team. A written response was not provided to this draft. The stated reason for this was that management was waiting on the finalization of protocols related to the issuance of OIG audit reports. Despite the lack of protocols, this final audit report was issued on October 30, 2008 pursuant to K.S.A. 75-7427(1), which states: "The scope, timing and completion of any audit or investigation conducted by the Inspector General shall be within the discretion of the Inspector General."

On January 9, 2009, the KHPA OIG received the official agency response to this audit report, which is included here as Appendix B.



December 12, 2008

Felany Opiso-Williams
Office of the Inspector General
Kansas Health Policy Authority
Room 900-N, Landon State Office Building
900 SW Jackson Street
Topeka, KS 66612

Dear Ms. Opiso-Williams:

OIG Conclusions and Recommendations 120908

The Kansas Health Policy Authority (KHPA) has received the Office of Inspector General's (OIG) report regarding its audit of the Medicaid fee-for-service home health program. I appreciate the opportunity to respond to the findings and recommendations included in the report.

The OIG examined claims and documentation and identified a number of potential concerns regarding the amount and scope of services provided. The audit included in-depth examination of a sample of home health claims, a review of home health statutory requirements, examination of home health audit findings in other states, and interviews of KHPA program managers and other staff. The findings and information conveyed in the report have contributed to the agency's understanding of this program.

KHPA staff share some of the same general concerns about home health services raised by the OIG, and as the field work for this audit was being conducted, identified a comprehensive set of reforms designed to address them. These reforms are the result of a year-long review of the Medicaid fee-for-service home health program as a component of the 2008 Medicaid Transformation process. This process began in January 2008 and includes fourteen separate data-driven reviews of the Medicaid program. The recommendations that came out of this process were reviewed by the KHPA Board and a set of Transformation initiatives were approved for implementation in fiscal year (FY) 2009, or recommended for inclusion in the agency's FY 2010 budget request. The home health program review included administrative recommendations to distinguish between acute and long-term home health services, and to institute universal prior authorization. These two core recommendations address many of the concerns raised by the OIG in their report, and provide an alternative to several of the specific

recommendations proposed by the OIG. KHPA accepts a number of the remaining OIG recommendations. Responses to the OIG's recommendations are summarized below.

The OIG recommends the following regarding appropriateness of payments:

1. KHPA should re-examine its prior authorization process to determine whether it is achieving the dual goals of ensuring consumers receive appropriate services and keeping unnecessary costs down. In particular, KHPA should address internal control weaknesses identified by this audit and only pay claims that are confirmed as medically necessary by physicians.

KHPA staff concurs with this recommendation to re-examine our process of prior authorization. Home health program changes proposed as a result of the 2008 Medicaid Transformation process will increase the use of prior authorization to ensure that services rendered meet medical necessity for skilled nursing visits. The home health program review prepared as a component of the Transformation process will be available on the agency's website in January 2009, and is available upon request from the agency.

2. In order to ensure KHPA only pays for services that are medically necessary for a consumer according to a physician-signed plan of care, KHPA should use those plans of care to set the number of services a home health agency may bill for that consumer.

KHPA staff believes the planned expansion of prior authorization for all home health services, coupled with existing documentation requirements, is sufficient to address the concerns raised by the OIG in this area.

Providers must submit a current plan of care when requesting a prior authorization, a requirement that will be universal under the changes being implemented through the Medicaid Transformation plan. As a matter of continuing policy, KHPA requires Medicaid home health agencies to first enroll as Medicare providers. As a Medicare provider, they are required to review the plans of care every 60 days, and to maintain those plans of care in their files. KHPA does not require providers to submit copies of the plan of care every 60 days. Providers must keep the plans of care in the clinical record, must submit a current plan of care with each prior authorization renewal for which services have been recertified by the physician, and plans of care must be available to KHPA upon request for post pay review. It often takes time to obtain physician's signatures on the appropriate (Medicare-generated) form, and the providers must submit the prior authorizations within specified time frames. Providers' records, including the plans of care, are reviewed as a part of the regulatory function performed by the Bureau of Licensure and Certification of the Kansas Department of Health and Environment.

Home Health staff promptly alert the physician to any changes that suggest a need to alter the plan of care in accordance with 42 CFR (Code of Federal Regulation) 484.18 (b). The home health nurse may receive telephone orders from the physician and submit this to the prior authorization unit when there is a change in frequency of visits. KHPA is concerned that requiring signed, current plans of care to be on file at KHPA as a condition of reimbursement would add significant administrative burden and delay a highly regulated process. The

requirement could result in a major back log and delay in reimbursement to home health agencies, and potentially impedes access to care.

3. KPHA should acquire and evaluate health assessment information found in the mandatory OASIS form for all Medicaid Home Health consumers, not just those requesting prior authorization in order to understand the population of consumers receiving these services, assess their needs, and shape program benefits to best meet those needs.

KHPA accepts this recommendation to acquire and evaluate OASIS (Outcome and Assessment Information Set) data to support plans for expanded use of prior authorization.

KHPA currently requires submission of OASIS assessments on each initial prior authorization request, and when renewals of that request entail a significant change in the beneficiary's condition. By extending the requirement for prior authorization to all home health recipients under the 2008 Medicaid Transformation recommendations, KHPA will effectively adopt the OIG's recommendation.

Although the OASIS data is an important source of information for individual home health users and could potentially be aggregated for use in policy planning, the costs of modifying the MMIS as suggested in the OIG audit – to enter this data into the MMIS on a routine basis -- would be high. KHPA does not plan to use OASIS data in this way, but looks forward to the enhanced data analytic capacity to be implemented in FY 2009 as a result of a legislatively-funded contract with Thompson-Reuters to construct and administer a modern decision-analytic database that includes Medicaid, state employee, and private insurance information.

The OIG recommends the following regarding accurate payments:

4. KHPA should annually monitor the progress EDS, the Medicaid fiscal agent, makes on its performance measures, as is required in the contract between KHPA and EDS.
5. KHPA should complete a data-driven program review, such as has been done for the Home Health FFS program, on the accuracy of the payment system, including an evaluation of the effectiveness of MMIS' edits and audits.
6. To support its goals to be a good steward of government funds, KHPA leadership should expressly articulate the importance of payment accuracy by setting that goal as one of the objectives in KHPA's strategic plan and communicating that priority to staff.

KHPA understands the sentiment expressed in the recommendation for improving payment accuracy, and welcomes specific suggestions from the OIG to better understand how the recommendations could best be implemented.

As a demonstration of its commitment to accuracy, the KHPA has adopted as one of its six vision principles a focus on stewardship, whereby "the KHPA will administer the resources entrusted to us by the citizens and the State of Kansas with the highest level of integrity,

responsibility and transparency” KHPA staff regularly monitors the performance of its fiscal agent, EDS, to ensure contract compliance. Moreover, the KHPA staffs focus on program integrity in collaboration with the Centers for Medicare and Medicaid Services (CMS) requires significant focus on accuracy of payments and program integrity.

KHPA employs a number of strategies to ensure accurate payments to providers, the most recent and comprehensive being the Payment Error Rate Measurement (PERM) Project. PERM addresses overall accuracy in payments and eligibility using a combination of statistical sampling and comprehensive claims review. The process is a result of Federal legislation and is mandated by CMS. The process includes an implicit review of the effectiveness of KHPA’s MMIS in ensuring compliance with CMS and state payment policies. However, PERM is not designed to detect nor measure provider fraud, ineffective policies, nor program performance. It is solely a measure of compliance with requirements for payment. For more information on PERM, please visit <http://www.cms.hhs.gov/PERM/> During the 2006 cycle of the PERM process, 24 home health claims were reviewed and only three errors were found, including one *underpayment* of a provider, one case of incorrect documentation (the provider entered an incorrect date when billing for services), and one case of un-recognized use of standard billing codes by KHPA (since corrected with new policies).

7. To increase its capabilities to monitor the Home Health FFS program, KHPA should collect identifying data about physicians ordering home health services and the home health agency employees actually providing the services.

KHPA staff does not concur with this recommendation because the financial and administrative costs of collecting additional information about physicians outweigh the potential benefits to the quality and accuracy of home health services.

Currently KHPA collects information for professional billing and performing providers. It would be difficult financially and administratively to coordinate a system by which providers could assign numbers to their employees to enter into MMIS. It is a requirement that home health agency employees document skilled nursing visits, home health aide visits and other services as specified. The documentation must include the signature of the nurse, aide or therapist that provided care. Please refer page 8-7 of the home health provider manual for documentation requirements. This information is available upon post pay review.

8. KHPA should require home health agencies to specify the actual dates services are provided to consumers, as opposed to simply identifying a date range within which services are provided, and then create the necessary edits in MMIS to verify compliance with KHPA policy.

KHPA staff recommends revisiting the potential value of this recommendation after implementation of universal prior authorization and other accepted recommendations and Medicaid Transformation initiatives.

The state Medicaid program began allowing providers to utilize date range billing to facilitate administrative simplicity for providers when a larger set of program changes was implemented in 2002. As a whole, those program changes helped produce significant reductions in home health expenditures. The use of date ranges allows for ease of billing. Date range billing is also utilized by the waiver programs. Providers bill for the first through the fifteenth of the month and the sixteenth through the thirtieth. There are currently edits and audits in the system that prevent providers from billing more than the average limitation in a specified date range for those beneficiaries that do not require prior authorization. For those individuals that require prior authorization, providers may submit claims and receive payment as long as the PA has billable units remaining. Should a provider bill all of the units specified in the PA request, there will be no units remaining by which to bill services. Additional units will not be approved without justification of medical necessity.

Another item for consideration is the additional cost that would result from no longer allowing date range billing. If providers are expected to bill each date of service on a separate claim line, this would result in additional claims to be processed since the CMS 1500 claim form has only six lines.

9. KHPA should direct home health agencies to bill for partial units of service based on actual minutes of service provided, instead of allowing providers to bill for 15-minute units regardless if one minute or 15 minutes for service are actually provided to a consumer.

KHPA concurs with this recommendation and plans to implement in concert with other reforms

The recommendation is to require home health agencies to bill by the minute of service, rather than in 15 minute intervals. It is feasible to implement this recommendation. The MMIS system currently has the capability to pay providers for partial units of service.

We observe partial unit billing mainly in non-prior authorized claims. With the proposed shift to prior authorization of all home health services, we propose to revisit this recommendation after implementing universal prior authorization. The MMIS is capable of quarter unit billing based on reported minutes of care.

10. KHPA should carefully manage its active provider identification numbers by: (1) implementing a table that identifies and cross references all provider identification numbers associated with a provider, and (2) by deactivating old provider numbers promptly.

KHPA concurs with this recommendation and will work with EDS to create a table in MMIS to cross reference provider identification numbers.

The OIG recommends the following regarding fraud prevention:

11. KHPA should take steps to identify when a home health agency bills for services allegedly provided during a time when the consumer is not living in his or her home and therefore is ineligible for home health services.

KHPA staff does not concur with this recommendation. Further review of the claims identified in the OIG audit found no evidence of fraudulent claims due to ineligible living arrangements was provided.

KHPA currently has restrictions in place that are utilized in processing home health claims such as place of service, provider type and specialty. Claims are paid according to these restrictions rather than by living arrangement or level of care assignments. This is important when dealing with claims for beneficiaries with a temporary care assignment. These are beneficiaries that are transitioning out of a facility placement to community living and may receive home health services while in the community but still assigned to a facility living arrangement.

12. To help identify fraud, KHPA should pursue increased communication with beneficiaries who serve as a natural check on the actions of providers. Methods to do so could include an increased number of mailings to consumers describing the services billed on their behalf or by using consumer satisfaction surveys.

KHPA concurs with this recommendation and plans to implement in concert with other reforms.

Increased communication with beneficiaries is expected with KHPA's new beneficiary web portal (BWP) which was made available for use in November of this year. Through this tool we can reach out to our beneficiary community by preparing survey questions, sending EOMBs through the BWP and requesting beneficiary reply. We will conduct periodic telephone contacts with beneficiaries on a specified interval, monthly, quarterly, or annually. The BWP will be the primary driver in the support of this recommendation. The display of claims history is not part of Phase 1 of the portal but it is in Phase 2. Phase 1 of the portal was implemented in November 2008. Displaying claims history will allow the beneficiary to review all of their Medicaid services similar to an EOMB letter.

The Beneficiary Web portal project also includes the Survey Monkey online survey tool that will allow KHPA and EDS to create customized surveys. Through the use of both of these tools we will be able to reach out to the beneficiary community and solicit feedback as well as sending specific EOMBs information viewable through the Beneficiary Web portal and ask them to review the services rendered.

The OIG recommends the following regarding cost savings:

13. When pursuing policy changes, KHPA should ensure that potential cost savings are considered for each proposal, and after implementation, verify whether cost savings were realized.

KHPA staff recommends further discussion and review of the recommendation to determine its feasibility.

To put this recommendation in some context, KHPA put into place 81 policies and 6 policy clarifications in fiscal year 2008, one indication of the administrative challenge of specifically tracking the impact of each policy. To better track the impact of program changes, KHPA has

instituted a set of comprehensive evaluations that encompass the home health program. These regular evaluations examine program trends, document program changes, and identify opportunities for improvements and savings. The 2008 program review of the Home Health program documented the impact of the most recent policy written for home health services addressed the telehealth benefit. The policy placed limitations on the frequency of visits of telehealth services and established criteria for prior authorization and medical necessity. Follow up to verify whether cost savings were realized revealed a decline in telehealth services and a significant cost savings. It must be noted that not all policies will result in a cost savings. Policies should be written to address the needs of fee for service home health beneficiaries in a fiscally responsible manner.

14. KHPA should consider placing limits on eligibility for home health services that are similar to limits used by Medicare, Missouri Medicaid and BlueCross BlueShield of Kansas, which require home health consumers to show some level of being homebound or meet specific criteria.

KHPA plans to defer policy questions on eligibility until the full effects of these changes are known.

KHPA has explored the use of homebound status for home health services. Implementation of home bound status would definitely tighten eligibility, but also has the potential to result in cost shifts to emergency room services or hospitalizations. There has been much discussion about Medicare's requirement of home bound status. However, Medicare is less stringent than it has been in the past.

The proposal would dramatically reduce the scope and reach of medical services provided through the home health program. The program changes proposed by KHPA in the 2008 Medicaid Transformation Plan are designed to better target home health services according to medical necessity with those changes; we expect a better correspondence between the care needed by Medicaid beneficiaries and the care provided.

15. KHPA should examine whether a co-payment should be required for other home health services besides skilled nursing.

KHPA staff does not concur with this recommendation because this would place undue financial burden on home health agencies and limit access to services for patients.

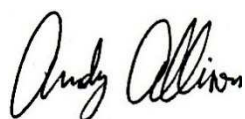
Currently there is a \$3.00 per skilled nursing visit co-payment required. Implementation of the OIG recommendation would place further financial burden on home health agencies, as many beneficiaries cannot afford the co-payment and home health agencies would have to absorb the cost of additional co-payments.

16. KHPA should consider cost savings strategies, such as:
 - a. Modifying the payment system to provide incentives to providers to encourage the provision of appropriate and quality care;

- b. Performing a vigorous analysis of home health agency practice patterns to identify inefficient providers and identify programmatic changes to encourage the efficient provision of services; or
- c. Paying physicians a fee to actively coordinate the care of consumers receiving home health services, consistent with the concept of a medical home.

KHPA concurs with this recommendation, which confirms the agency's decision to conduct a year long comprehensive review of the fee for service home health program in 2008. This review supports recommendations to improve cost-effectiveness and better match services provided to those in need.

Sincerely,

A handwritten signature in black ink that reads "Andy Allison". The signature is written in a cursive, flowing style.

Dr. Andrew Allison, Deputy Director
Medicaid Director